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Sexual Violence Victimization and Associations with Health in a Community Sample of African American Women

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Abstract

Limited information exists on the relationship between sexual violence victimization and health among African American women. Using data from a community sample of African American women, we examine the association between current health and lifetime experiences of sexual violence. Inperson interviews were completed in 2010. Among interviewees, 53.7% of women reported rape victimization and 44.8% reported sexual coercion in their lifetime. Victims of rape or sexual coercion were significantly more likely to report depression and posttraumatic stress disorder during their lifetime. Among victims whose first unwanted sexual experience was rape or sexual coercion, perpetrators were mostly acquaintances and intimate partners, and over one third were injured and needed services. More attention is needed on the health needs of African American women and their association to victimization status.

Keywords

Help-seeking; negative health experiences; rape; sexual coercion

Although sexual violence (SV) occurs across all ethnic and racial groups, research has increasingly pointed to the prevalence and adverse health outcomes of SV among specific groups, such as African American women and other ethnic and racial minorities (Black et al., 2011; Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010; Lacey, McPherson, Samuel, Sears, & Head, 2013; Young & Boyd, 2000). Due to the limited number of studies and the complex nature and consequences of SV victimization for African American women, further research is needed.

There is a substantial literature focused on the health-related consequences of SV (Lang et al., 2003; Smith & Breiding, 2011). Prior work has shown, for example, that sexually victimized women are more likely to experience many chronic health conditions, HIV risk factors, smoking, and excessive drinking (Smith & Breiding, 2011). But most of the literature comes from population samples that are not large enough to stratify by race or ethnicity. As a result, less is known about the extent to which particular racial and ethnic

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groups, including African American women SV survivors, experience these types of negative health indicators. In this study, SV victimization status and specific health associations are identified (e.g., mental, physical, and behavioral health conditions, and postvictimization services received) in a community sample of African American women.

Definitional components

The literature on SV uses various terms and definitions to examine this public health problem, including sexual assault, sexual coercion, and rape. These terms often overlap in definitions and are used interchangeably. For the purpose of this study, SV includes physically forced nonconsensual completed or attempted penetration, penetration when the victim was not able to consent because she was passed out or asleep (rape), or unwanted penetration that is not physically forced (sexual coercion; Basile, Smith, Breiding, Black, & Mahendra, 2014).

The extent of SV among African American women

Despite the large body of literature examining SV, large nationally representative studies focusing specifically on racial and ethnic minority women are limited. Further, much of the previous scholarship that does exist on SV of African American women is focused on rape and other penetrative SV acts (i.e., sexual coercion), perhaps given the seriousness of these kinds of SV victimization and their association with adverse health. Some national prevalence studies have examined rape by racial and ethnic identity. For example, the National Violence Against Women Survey (NVAWS) found that 18.8% of African American women had experienced rape in their lifetime (Tjaden & Thoennes, 1998). A study using data fromthe National Crime Victimization Survey found that from 2005 to 2010, approximately 3 African American women per 1,000 reported experiencing sexual assault since age 12 (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). Kilpatrick, Resnick, Ruggiero, Conoscenti, and McCauley (2007) conducted a national telephone study using both community and college samples. These samples reported that African American women reported higher rates of lifetime forcible rape than non-Hispanic White women, Hispanic women, and Asian women. More recently, the National Intimate Partner and Sexual Violence survey (NISVS) found that 13.6% of Hispanic women, 21.2% of non-Hispanic Black women, 20.5% of non-Hispanic White women, and 27.5% of American Indian/Alaska Natives reported experiencing rape during their lifetime (Breiding et al., 2014). Several smaller studies have also focused on the differences in SV by race or ethnicity. Molitor, Ruiz, Klausner, and McFarland (2000) recruited young women from a community sample of low-income neighborhoods in five counties in California. Of more than 2,500 young women, 24.0% reported they had experienced forced sex (30.0% of African Americans, 32.0% of Whites, 14.4% of Hispanics, and 30.0% of multiracial women). The aforementioned studies illustrate the range of SV prevalence across samples of racial and ethnic minority women. Despite such variation, findings consistently reveal a high burden of SV victimization among African American women and other racial and ethnic minority groups. Given this burden, it is imperative to explore the health of African American women SV survivors as it can improve our understanding of the risks for this

population, and ultimately informthe development of effective interventions to address their needs.

Health risks and adverse conditions for African American women SV survivors

A substantial body of literature documents the risks of SV victimization to physical, mental, and behavioral health, indicating that SV survivors are more likely to experience adverse health compared to non-SV victims (Koss, Koss, & Woodruff, 1991; McFarlane et al., 2005; Pico-Alfonso et al., 2006; Rivara et al., 2007). Moderate to high rates of SV (e.g., 22%–100%) are reported in various samples of predominantly African American women, including substance abuse treatment recipients (Young & Boyd, 2000), low-income samples (Boyd, Henderson, Ross-Durow, & Aspen, 1997; Bryant-Davis et al., 2010; Dailey, Humphreys, Rankin, & Lee, 2011; Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998), and military veterans (Campbell, Greeson, Bybee, & Raja, 2008).

Adverse mental and behavioral health

Depression, posttraumatic stress disorder (PTSD), substance use disorders (SUDs), and suicidality are common mental and behavioral health problems among SV survivors in general (Alim et al., 2006; Caetano & Cunradi, 2003; Iverson et al., 2013; Ramos, Carlson, & McNutt, 2004). In a U.S. national sample, a history of SV has been found to be associated with anxiety disorders, mood disorders, PTSD, SUDs, and suicide attempts (Iverson et al., 2013). Studies focusing on the mental and behavioral health of African American female SV survivors in particular are limited, and the studies that exist usually rely on urban, low socioeconomic status (SES), or drug-abusing samples (Boyd et al., 1997; Bryant-Davis, Chung, & Tillman, 2009; Bryant-Davis et al., 2010; Campbell et al., 2008; Vaszari, Bradford, CallahanO'Leary, Ben Abdallah, & Cottler, 2011). For example, in a community sample of low-income, ethnically diverse women ($N = 835$), Temple and colleagues (2007) found that sexual assault by current partners and nonpartners was a significant predictor of PTSD symptoms for African American women. Depression is consistently found to be a health risk for African American SV survivors (Alim et al., 2006; Ramos et al., 2004). Data from 462 women (87% African American) who were cocaine users showed that 43.3% reported sexual assault victimization. Among the African American women in the sample, 85% reported suicidal ideation. Similarly, in terms of comorbidity, in a sample of African American women recruited from an urban hospital ($n = 335$), Thompson and colleagues (2000) found that women with a history of child sexual abuse and current PTSD symptoms were more likely than women without a child sexual abuse history or PTSD to attempt suicide.

Although a concern for all survivors, adverse mental health and substance use problems could be particularly problematic for African American women SV survivors due to their risk for multiple, overlapping public health problems and conditions (Bryant-Davis et al., 2010). For example, Bryant-Davis and colleagues (2010) explored the relationship between poverty and mental health outcomes in an urban community sample of African American

female SV survivors ($N = 413$). Positive relationships were found between poverty and depression, PTSD, and illicit drug use in the sample.

Other adverse conditions and life consequences

A body of studies with samples of African American women either examined the role of income or poverty as a correlate of SV (Bryant-Davis et al., 2010; Ingram, Corning, & Schmidt, 1996), or included high numbers of respondents with both low SES and high rates of SV victimization (Kalichman et al., 1998; McFarlane et al., 2005; Temple et al., 2007; Vaszari et al., 2011). Due to no or low income, African American women with low SES are often resigned to homelessness or low-income housing in communities where they are at increased risk for multiple violence exposures (Abbey, Parkhill, Jacques-Tiura, & Saenz, 2009; Jenkins, 2002). In addition to housing insecurity, food insecurity is another potentially related adverse condition for impoverished African American women SV survivors. Although food insecurity, as a factor of poverty, has not been directly explored in the literature, it is related to women's ability to meet their own as well as their children's basic needs. Overall, poverty and low SES are associated with increased rates of SV among African American women (Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999; Honeycutt, Marshall, & Weston, 2001; Kalichman et al., 1998).

Help-seeking and service needs

The help sources typically sought by SV survivors include reporting assaults to police, obtaining protection orders (POs), receiving emergency medical services (EMS) and emergency trauma department care, turning to social support networks, and, in some cases, seeking mental health services and victim shelter services (Bryant-Davis, Ullman, Tsong, & Gobin, 2011; Kothari et al., 2012). Yet, the majority of all sexual assaults are not reported or shared with social services or law enforcement (Hanson et al., 2003), and often survivors who need medical care and counseling do not receive it (Resnick et al., 2000). National data indicate that approximately one fourth (26.2%) of adult rape survivors seek medical care after the assault (Resnick et al., 2000). The National Crime Victimization Survey (NCVS) estimates that in 2010 only 35% of the sexual assaults experienced by women (regardless of their relationship to the perpetrator) were reported to police (Planty et al., 2013).

Relatively few studies have investigated post-SV help-seeking characteristics and correlates specifically among African American women SV survivors (Zinzow, Resnick, Barr, Danielson, & Kilpatrick, 2012). A small number of researchers have focused on increasing the attention in the literature on what Bryant-Davis and colleagues (2011) called the "cultural context of sexual assault recovery" (p. 1602). For example, Flicker et al. (2011) investigated the differential impact of concomitant forms of violence (sexual violence, stalking, and psychological aggression) and ethnicity on help-seeking behaviors of female partner abuse survivors. The authors found racial differences related to specific help-seeking behaviors. For example, African American women survivors were more likely to seek police help and orders of protection compared to White women, which appears to be consistent with other findings (Bachman & Coker, 1995; Lipsky, Caetano, & Roy-Byrne, 2009; Pearlman, Zierler, Gjelsvik, & Verhoek-Oftedahl, 2003). Yet, Kothari et al. (2012) found, in

a sample of women survivors of partner violence (including SV) for which the police were involved, that African American women survivors were less likely to obtain protective orders than White women survivors. Such inconsistencies suggest the influence of contextual and cultural factors on the help-seeking behaviors of women survivors (Bent-Goodley, 2007; Boykins et al., 2010).

In terms of contextual factors, the nature of the rape experience seems to matter. Boykins and colleagues (2010) found that Black women SV survivors were more likely to have reported weapons used in their assaults and use of illicit drugs when compared to White women survivors. The context of the rape incident and experience could affect African American women survivors' propensity to seek help from the emergency department as a primary source of care for this population (Boykins et al., 2010; Koss et al., 1991) over other types of help sources, as well as the experience of weapon-inflicted injuries requiring such specific care.

Similarly, cultural factors and values can also influence help-seeking. Culturally preferred sources of help, for example, for African American women generally come from informal support networks of family and friends, and faith-based resources and activities instead of more formal help sources such as mental health counseling (Bent-Goodley & Fowler, 2006; Bryant-Davis et al., 2011; Henning & Klesges, 2002). Taken together, more information is needed to better understand the victimization experiences, related risks, and help-seeking characteristics (i.e., types of services sought and obtained) for African American women SV survivors.

This study

The purpose of this study is to share findings from a community sample of African American women about their rape and sexual coercion victimization and its association with numerous negative mental and physical health indicators as well as health-related behaviors. This study also builds on previous studies that have addressed SV-related health risks in this population. Findings from this study provide an in-depth examination of the health burden associated with penetrative forms of SV victimization among a racial and ethnic group of women for which little information is available on health-related associations.

Methods

Participants

For this study, 168 African American women completed a face-to-face paper-and-pencil interview. Eligibility requirements for this study were being female, English-speaking, African American, and 18 years or older. Descriptive analyses were conducted using the full sample. The women's ages ranged from 18 to 93 years old, with an average age of 48. Forty-two percent (42.4%) of the sample was never married. Sixty-eight percent (68.3%) completed high school or greater. The women's total household incomes varied, but tended to be low: 29.1% of participants reported an annual income of less than $5,000; 12.7% reported an annual income of $5,000 to $9,999; 12.1% reported annual income of $10,000 to

$14,999, 17.6% reported earning between $15,000 and $24,999, 16.4% reported annual income of $25,000 to $49,999, and 12.1% reported earnings of $50,000 or greater.

Procedures

To ensure that interview questions were clearly interpreted and the instrument was culturally appropriate, a pilot test of an African American sample of women was conducted and the instrument was fine-tuned. To locate African American women to complete the main study interviews, African American urban neighborhoods in a Southeastern U.S. city and addresses within those neighborhoods were randomly chosen and interviewers went to those addresses to determine whether eligible women lived there. A total of 322 women were screened for eligibility for the study, and 219 women were deemed eligible. Of them, 168 women were interviewed for a completion rate of 76.7%. Potential participants were initially told that the study was about women's health and well-being. As a safety precaution, interviewers were instructed to reveal the specific nature of the survey—sexual violence—only to the selected participant in a safe, private location. Interviews were conducted between May and July 2010. The interviews were conducted in person in a private location (most often at the participant's home) and lasted from 20 minutes to 2 hours, depending on the participant's experiences with SV. All women in the study received $20 as a token of appreciation. Interviewers read the questions and response options to participants or showed them a card with a list of the response options pertaining to the question being asked.

Measures

Participants were asked a range of questions about their health and SV victimization, including rape and sexual coercion. For all items, responses of "don't know" were recoded as missing.

History and tactics of SV—To determine their history of SV victimization, women were asked how many times in their life they experienced a form of completed or attempted sex (vaginal, anal, or oral) that was unwanted. Rape items consisted of completed or attempted sex after a perpetrator used physical force or threats of physical harm; gave the victim drugs or alcohol; or when the sex occurred when the victim was passed out, asleep, drunk, or high (and unable to provide consent to sex). Sexual coercion items consisted of completed sex after a perpetrator did any of the following: told lies, made false promises about the future, or threatened to end a relationship or spread rumors; wore down the victim by repeatedly asking for sex; or used his or her influence or authority to make the victim engage in unwanted sex.

For all SV items, response options were never, *1 time, 2 to 5 times, 6 to 10 times*, and *more than 10 times*. Responses were recoded into dichotomous responses to indicate whether the respondent was *ever* victimized: 0 = *never;* 1 = *1 time, 2 to 5 times, 6 to 10 times, or more than 10 times*.

Negative health behaviors and financial concerns

Alcohol and drug use: All participants were asked (a) how often they engaged in binge drinking and (b) how often they used illegal drugs or misused prescription drugs in the past

12 months. Response options for each question were 0 = *never*, 1 = *less than monthly*, 1 = *monthly*, 2 = *weekly*, 3 = *daily or almost daily* and recoded into 1 = *yes, any use* and 0 = *no use*.

Food and housing insecurity: All participants were asked questions regarding how often they were worried or stressed about (a) their ability to pay their rent or mortgage, and (b) to buy nutritious meals during the previous 12 months. Response options for each question were *always, usually, sometimes, rarely, never*, or *don't know* and recoded into 1 = *yes, any worry* and 0 = *no worry*.

Lifetime mental health conditions

Depression and suicidality: Participants were asked to indicate whether they ever felt sad, down, or hopeless almost every day for 2 weeks or more, had little interest or pleasure in doing things almost every day for 2 weeks or more, seriously considered attempting suicide, or actually attempted suicide. Response options were coded dichotomously: 1 = *yes*, 0 = *no*.

PTSD: Participants were asked to indicate whether they ever had an experience that was so frightening, horrible, or upsetting that for at least 1 month they had nightmares about it or thought about it when they did not want to; tried hard not to think about it or went out of their way to avoid situations that reminded them of it; were constantly on guard, watchful, or easily startled; or felt numb or distant from others, activities, or their surroundings. Response options were coded dichotomously: 1 = *yes*, 0 = *no*.

First unwanted sexual experience was rape or sexual coercion—Among participants who endorsed any item of rape or sexual coercion during their lifetime, we focused on those victims whose first unwanted sexual experience was rape or sexual coercion. Several variables were analyzed for this subset.

Age of victim: Age at first rape or sexual coercion was measured using the following response options: 12 or younger, 13 to 17, 18 to 29, 30 to 44, 45 to 59, 60 to 64, 65 or older, and don't know.

Age of perpetrator: Age of the perpetrator during the victim's first rape or sexual coercion was measured using the following response options: 12 or younger, 13 to 17, 18 to 29, 30 to 44, 45 to 59, 60 to 64, 65 or older, and don't know.

Type of perpetrator: Participants were asked to indicate how they knew the perpetrator. Four types of perpetrators were used to categorize responses: (a) *intimate partner*: current or former boyfriend, girlfriend, romantic partner, or significant other; current or former legal spouse, including common law; or someone they were dating but who they would not label as a boyfriend or girlfriend; (b) *friend/acquaintance*: friend; acquaintance; someone they were on a first date with; someone in a position of power or trust (e.g., employer, teacher, clergy, police officer); or someone else they knew; (c) *family member;* and (d) *stranger*.

Physical health conditions and services related to their first unwanted sexual experience which resulted in rape or sexual coercion

Injury: Participants were asked to indicate whether they experienced injuries from the rape or sexual coercion that resulted from their first unwanted sexual experience. Participants were specifically asked whether they experienced minor bruises or scratches; cuts, major bruises, or black eyes; broken bones or teeth; being knocked out after getting hit, slammed against something, or choked; or other injuries. Response options for each type of injury were coded dichotomously: 1 = *yes*, 0 = *no*.

STD/HIV: In separate questions, participants were asked to indicate whether they contracted a sexually transmitted disease or whether they contracted HIV from the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = *yes*, 0 = *no*.

Pregnancy and outcome of pregnancy: Participants were asked to indicate whether (yes–no) they got pregnant from the rape or sexual coercion that resulted from their first unwanted sexual experience. If they answered yes, they were asked what happened to the pregnancy. Response options were birthed and kept the baby, birthed the baby and placed him or her for adoption, had a miscarriage, had an abortion, or don't know. In addition, participants were asked whether they lost an existing pregnancy as a result of their first experience of rape or sexual coercion; response options were coded dichotomously: 1 = *yes*, 0 = *no*.

Rape kit exam: Participants were asked to indicate whether they underwent a rape kit exam after the rape or sexual coercion that resulted from their first unwanted sexual experience: Did a doctor or nurse take any physical evidence from you (for example, samples of bodily fluid for a "rape kit")? Response options were coded dichotomously: 1 = *yes*, 0 = *no*.

Medical services, care, and hospitalization: Participants were asked to indicate whether they needed medical care from a doctor or nurse due to the rape or sexual coercion that resulted from their first unwanted sexual experience. If they indicated yes, then they were asked if they were able to get the medical care they needed. In addition, participants were asked to indicate whether they have to stay at a hospital or get other inpatient medical care as a result of their experience of rape or sexual coercion. Response options for all questions were coded dichotomously: 1 = *yes*, 0 = *no*.

Mental health services: Participants were asked to indicate whether they needed mental health care from a therapist, counselor, or other mental health care provider due to the rape or sexual coercion that resulted from their first unwanted sexual experience. If they indicated yes, then they were asked if they were able to get the mental health services they needed. Response options for all questions were coded dichotomously: 1 = *yes*, 0 = *no*.

Other services: Participants were asked to indicate whether they needed housing services, community services, victim's advocate services, and whether someone contacted the police due to the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = yes, 0 = no.

Other consequences of the first unwanted sexual experience which was rape or sexual coercion—Participants were asked to indicate whether they felt safe in the neighborhood where they lived, whether they missed work, whether they stayed with family members or friends, and whether they relocated from the area in which they lived due to the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = *yes*, 0 = *no*.

Analyses

First, we conducted descriptive analyses to verify racial identification. Three participants were removed from the analysis sample because they did not identify as African American, bringing the final sample to 165. Next, we conducted analyses to determine the percentage of women from this community sample who experienced rape, sexual coercion, or both in their lifetime. Next, we performed chi-square analyses to test for a relationship among mental health experiences, alcohol and drug use, and financial concerns and lifetime rape or sexual coercion victim status. Second, we examined more closely the use of alcohol and drugs, and financial concerns among lifetime victims of rape or sexual coercion. Finally, we provide descriptive statistics regarding the characteristics and outcomes of women's first unwanted sexual experience that was rape or sexual coercion.

Results

Lifetime experiences of rape or sexual coercion in full sample

In the full sample, over half of participants indicated they were victims of rape, sexual coercion, or both. More specifically, 53.7% of women reported rape victimization and 44.8% reported sexual coercion in their lifetime. About 42% (42.3%) of the full sample experienced both rape and sexual coercion in their lifetime.

Mental health experiences—Overall, 63.8% of the full sample experienced at least one symptom of PTSD, and 50.0% experienced at least one symptom of depression during their lifetime. Chi-square tests were performed, which revealed statistically significant relationships between victimization status of lifetime experience of rape or sexual coercion and individual symptoms of PTSD and depression (see Table 1); lifetime experience of rape or sexual coercion and any symptom of PTSD, $\chi^2(1, N = 163) = 13.7986$, $p = .001$; and lifetime experience of rape or sexual coercion and any symptom of depression, $\chi^2(1, N = 164) = 22.2826$, $p = .001$.

In addition, 20.9% of women in the full sample seriously considered suicide during their lifetime; among those women, 88.2% also had a history of rape or sexual coercion in their lifetime. Among only the women who seriously considered suicide, 41.2% actually attempted suicide. Among women who both seriously considered and attempted suicide, 92.9% were also victims of rape or sexual coercion in their lifetime.

Negative health behaviors and financial concerns in previous 12 months

Food and housing insecurity—In the full sample, 55.2% and 73.9% of participants indicated that they worried about their ability to buy nutritious meals and pay their rent or

mortgage during the past 12 months, respectively. Chi-square tests revealed significant relationships between rape or sexual coercion victimization status and both food and housing insecurity: 66.3% of victims and 40.3% of nonvictims were concerned about their ability to buy nutritious meals during the previous year, $\chi^2(1, N = 164) = 11.0490$, $p = .001$. In addition, the chi-square analysis indicated that 81.5% of victims and 63.9% of nonvictims worried about their ability to pay their rent or mortgage during the previous year, $\chi^2(1, N = 164) = 6.4917$, $p = .011$.

Alcohol and drug use—In the full sample, 42.9% and 14.0% of participants engaged in binge drinking and illegal drug use or prescription drug misuse during the past 12 months, respectively. A chi-square test revealed a significant association between rape or sexual coercion victimization status and binge drinking in the past 12 months: 49.5% of victims and 33.8% of nonvictims engaged in binge drinking during the previous 12 months, $\chi^2(1, N = 162) = 3.9938$, $p = .046$. Chi-square tests were not performed on drug use due to low cell sizes.

Experiences among victims of lifetime rape or sexual coercion

In this section the findings presented are among lifetime victims of rape or sexual coercion only ($n = 92$).

Negative health behaviors and financial concerns in previous 12 months among lifetime victims of rape or sexual coercion

Alcohol and drug use: Among lifetime victims of rape or sexual coercion, a total of 49.5% indicated that they engaged in binge drinking (i.e., drank 4 or more alcoholic beverages on one occasion) at some point in the previous 12 months on a monthly, weekly, or daily basis. Additionally, 10.9% reported that they engaged in illegal drug use/prescription drug misuse on a daily or almost daily basis in the last 12 months (see Figure 1).

Food and housing insecurity: Among lifetime victims of rape or sexual coercion, 81.5% were concerned about paying their rent or mortgage, and 66.3% were concerned about their ability to pay for nutritious meals during the previous 12 months (see Figure 2).

Characteristics of victims whose first unwanted sexual experience was rape or sexual coercion—Victims were asked a series of questions about their first unwanted sexual experience, such as their age when it happened and the person who victimized them. Here, we focus on those whose first unwanted sexual experience was rape or sexual coercion ($n = 80$).

Of the 80 women who reported that rape or sexual coercion occurred during their first unwanted sexual experience, 73.4% ($n = 58$) reported that the violence occurred when they were under the age of 18. In Figure 3 we present the women's ages at their first unwanted sexual experience resulting in rape or sexual coercion.

Age and type of perpetrator: Among the women who reported a rape or sexual coercion as their first unwanted sexual experience, perpetrators were male (98.8%), the same race

(96.3%), and known (90.0%) to the women in some capacity. We examined the victims' age and type of perpetrator during their first unwanted sexual experience resulting in rape or sexual coercion. Among victims who were 12 and younger, perpetrators were mostly friends or acquaintances (46.2%) or family members (42.3%). Of victims who were 13 to 17, perpetrators were mostly friends or acquaintances (53.1%) or intimate partners (28.1%). Among those who were 18 to 29, perpetrators were mostly intimate partners (47.1%) or friends or acquaintances (41.2%). Finally, among victims who were 30 to 44, perpetrators were split between intimate partners (50.0%) and friends or acquaintances (50.0%). See Table 2.

Consequences experienced by women whose first unwanted sexual experience resulted in rape or sexual coercion

Physical health outcomes: Among women whose first unwanted sexual experience resulted in rape or sexual coercion, 39.7% of victims suffered injuries (ranging from minor cuts to being knocked out). Approximately 4% (3.8%) and 8% (7.8%) reported contracting HIV or a sexually transmitted disease, respectively. In addition, 17.9% of victims became pregnant as a result of this experience (see Table 3).

Services sought and obtained: The women whose first unwanted sexual experience resulted in rape or sexual coercion sought a variety of services, including medical care, mental health care, community services, housing, victim advocacy, and police assistance. Findings revealed that 35.1% of victims needed medical services, and of them, 55.6% were able to obtain those services; 15.4% of all victims underwent a rape kit exam. Over one quarter of victims (26.3%) stated that the police were contacted after the incident. Moreover, 36.2% reported that they needed mental health services, and about half (51.7%) of those were able to obtain them. Approximately 13% to 14% needed services provided by the community (13.9%), housing (12.8%), or victim advocacy (12.8%; see Table 3).

Other consequences: Women whose first unwanted sexual experience resulted in rape or sexual coercion were asked about other consequences that affected their daily lives after this first unwanted experience. About 6% (6.3%) of victims missed work because of the incident. Additionally, 42.3% stated that they felt unsafe in their neighborhood afterward. Thirty-eight percent of victims reported that they stayed with family or friends, and 32.5% decided to relocate or move from their residence.

Discussion

African American women are victims of SV at high rates, as consistently evidenced by previous national prevalence studies (Black et al., 2011; Breiding et al., 2014; Tjaden & Thoennes, 1998). There is less information available about the health associations linked to SV victimization for African American women in particular. Understanding the physical and mental health correlates and impact of SV among specific segments of the population at high risk (i.e., African American women) is important to (a) better contextualize the SV victimization experience, and (b) help inform and tailor prevention efforts. Although the focus of this study is on a relatively small community sample that is not representative of all

African American women in the United States, this sample is important because it provides a fuller picture of the context and circumstances around SV victimization of a high-risk urban sample of women. The findings help to highlight the high prevalence of SV victimization and its health consequences for some racial and ethnic minority women.

Findings from this study reveal a high prevalence of rape and sexual coercion victimization among this community sample of African American women (53.7% experienced rape and 44.8% experienced sexual coercion at some point in their lives). These prevalence estimates are higher than previous national survey estimates (Black et al., 2011; Breiding et al., 2014; Tjaden & Thoennes, 1998), but are consistent with other community-based studies of African American women (Bryant-Davis et al., 2010; Kalichman et al., 1998). In addition, the face-to-face nature of data collection in this study could have also increased disclosure (Tillman, Bryant-Davis, Smith, & Marks, 2010). Results reveal that mental health conditions, alcohol use, and financial concerns are associated with previous SV victimization. For example, being a victim of rape or sexual coercion was associated with endorsing at least one PTSD symptom and symptoms of depression in their lifetime. In other findings, a high percentage of lifetime victims of rape or sexual coercion engaged in binge drinking during the previous year, and over 10% reported that they abused prescription drugs or used illegal drugs on a daily or almost daily basis in the last 12 months.

Of those whose first unwanted sexual experience resulted in rape or sexual coercion, the majority of victims were younger than 18 years of age, were the same race as their perpetrator, and knew their perpetrators (intimate partners, family members, or acquaintances) at the time of their assault. These findings are consistent with results from previous studies of African American women (Avegno, Mills, & Mills, 2009; Weist et al., 2007). The consequences experienced by victims whose first unwanted sexual experience resulted in rape or sexual coercion (e.g., physical consequences, service needs, and impacts on daily living) are consistent with previous literature (Avegno et al., 2009; Weist et al., 2007). Regarding the impact of rape or sexual coercion on a victim's daily life, many women no longer felt safe in their neighborhood as a result of their assault. Others chose to stay with family or friends after their attack and some chose to relocate or change residence afterward. These findings are consistent with the work of Frazier and colleagues, who found in their study of 171 sexual assault survivors that after their assault women believed their world was no longer safe and they held negative attitudes regarding fairness of life and goodness of people (Frazier, Conlon, & Glaser, 2001).

In addition, various services were needed and sought by victims in this sample whose first unwanted sexual experience was rape or sexual coercion. These included medical care, mental health care, community services, housing, victim advocacy services, and assistance from the police. Approximately one third of victims needed either medical or mental health services. However, only about half of those who required these services were able to obtain the help they needed. In addition, only one quarter of victims whose first unwanted sexual experience was rape or sexual coercion contacted the police after their experience. These findings suggest the disinclination of African American women to seek help from mental health services (Henning & Klesges, 2002; Snowden, 2001) and, in some cases, from law enforcement and the criminal justice system, which might reflect a cultural tendency among

this population to distrust helping professionals due to historical mistreatment, and a lack of culturally competent services (Flicker et al., 2011; Raj et al., 1999; Tillman et al., 2010). Compounded by increased exposure to SV, racial and structural inequities, including the experience of discrimination, might increase African American women survivors' risk for poor outcomes.

These findings as a whole support previous research suggesting the multiple sociocultural hardships faced by African American women might be exacerbated by SV victimization or might, in some cases, lead to SV victimization. For example, the majority of the participants in our sample fell below the poverty threshold for a family of two adults without children. In addition, the majority of lifetime rape or sexual coercion victims expressed they had financial concerns within the 12 months prior to the survey and they were significantly more likely to have these concerns than nonvictims. These included concerns about being able to pay their rent or mortgage and their ability to afford healthy meals. Previous research has shown that women are at increased risk of victimization when their income is below the poverty line, and conversely, victimization increases women's likelihood of unemployment and reduced income (Byrne et al., 1999). In 2010, 46.6% of African American female, single-parent households were impoverished (Entmacher, Robbins, & Vogtman, 2014). African Americans live at disproportionately lower socioeconomic levels with less access to resources than their White counterparts (DeNavas-Walt, Proctor, & Smith, 2013). The added burden of traumatic SV victimization for women living in poverty potentially exacerbates the need for multiple services and resources to address various intersecting problems (i.e., poverty, victimization, mental and physical health; Bryant-Davis et al., 2009).

This study is a contribution to the literature on the impact of SV victimization of African American women because it included many health associations and circumstances of the violence, which enabled a well-rounded picture of the SV experience. In addition, the measurement of SV victimization included in this study was very detailed, including numerous tactics, which likely improved disclosure. However, this study has some limitations. First, the sample is from an urban neighborhood in a Southeastern U.S. city, so the findings might not be generalizable to all African American women. Second, the sample is relatively small, which limited our ability to conduct more complex statistical testing. Also, the study only included one racial and ethnic group of women so it did not enable comparisons to other groups. In addition, the analyses conducted in this study only focused on rape and sexual coercion, and other types of SV such as unwanted sexual contact are not represented. The main SV variable used in this study combined rape and sexual coercion. Ideally, we would have examined rape experiences and sexual coercion victimization experiences separately so that we could determine if there were differences in the health associations linked to these two forms of sexual violence. However, the experiences of the women in our sample did not enable us to examine rape and sexual coercion separately because a relatively large subset of the women in our sample experienced both rape and sexual coercion.

Overall, the findings from this study have important implications for prevention, practice, and service response to African American victims of SV. Given the alarming numbers of women in this study who experienced rape and sexual coercion that caused injuries and

other physical and mental health problems, primary prevention of SV has the potential to prevent numerous adverse health experiences and the costs associated with them. In addition, the high rates of adverse physical and mental health experiences among victims of SV in this sample suggest that African American women are in particular need of ongoing health-related services, whether or not they disclose their victimization status. Although our findings suggest a need for these types of services, only a little more than 50% of women in our sample were able to get the physical and mental health services they needed.

Some have suggested that African American women's SV-related health risks, adverse conditions, and challenges with regard to seeking services are intricately linked to race or ethnicity and culture (Bent-Goodley, 2007; Boykins et al., 2010; Flicker et al., 2011; Tillman et al., 2010). This study supports prior research suggesting an association between SV victimization and numerous physical and mental health risks and behaviors. More scholarship in this area with representative samples of African American women and other racial and ethnic minority women are important to inform prevention practice. Larger and more representative samples are needed for future research on the health associations linked to SV victimization, and to enable comparisons across different racial and ethnic groups. Further, the important connections among adverse health, SV, and cultural differences need further exploration to inform practice.

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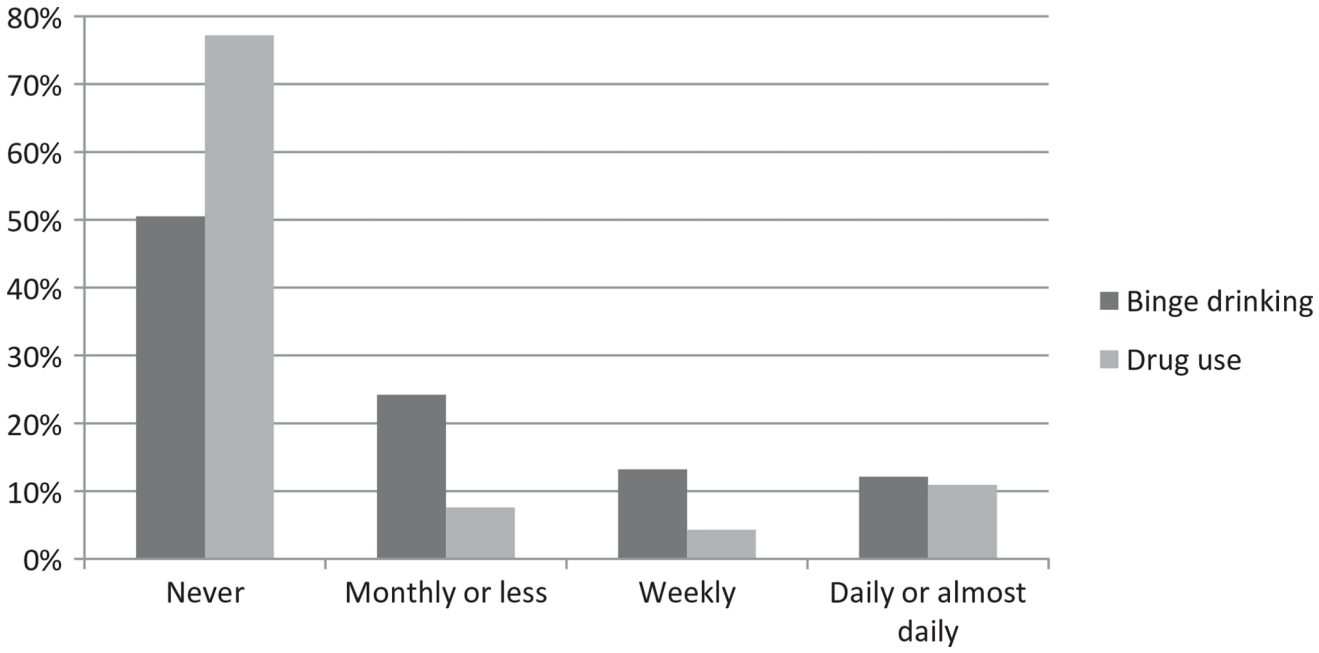

Figure 1.
Alcohol and drug use among lifetime victims of rape or sexual coercion, previous 12 months ($N = 92$).

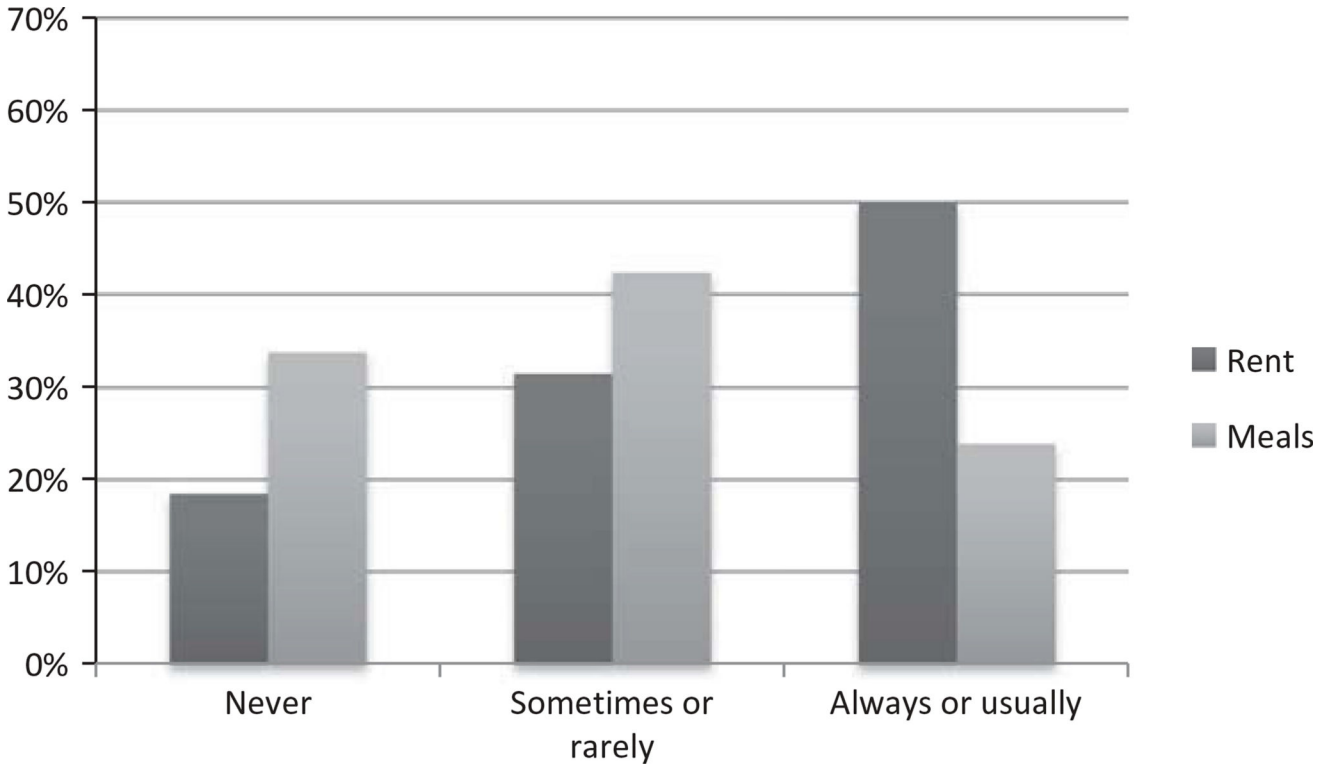

Figure 2.
Financial concerns among lifetime victims of rape or sexual coercion, previous 12 months ($N = 92$).

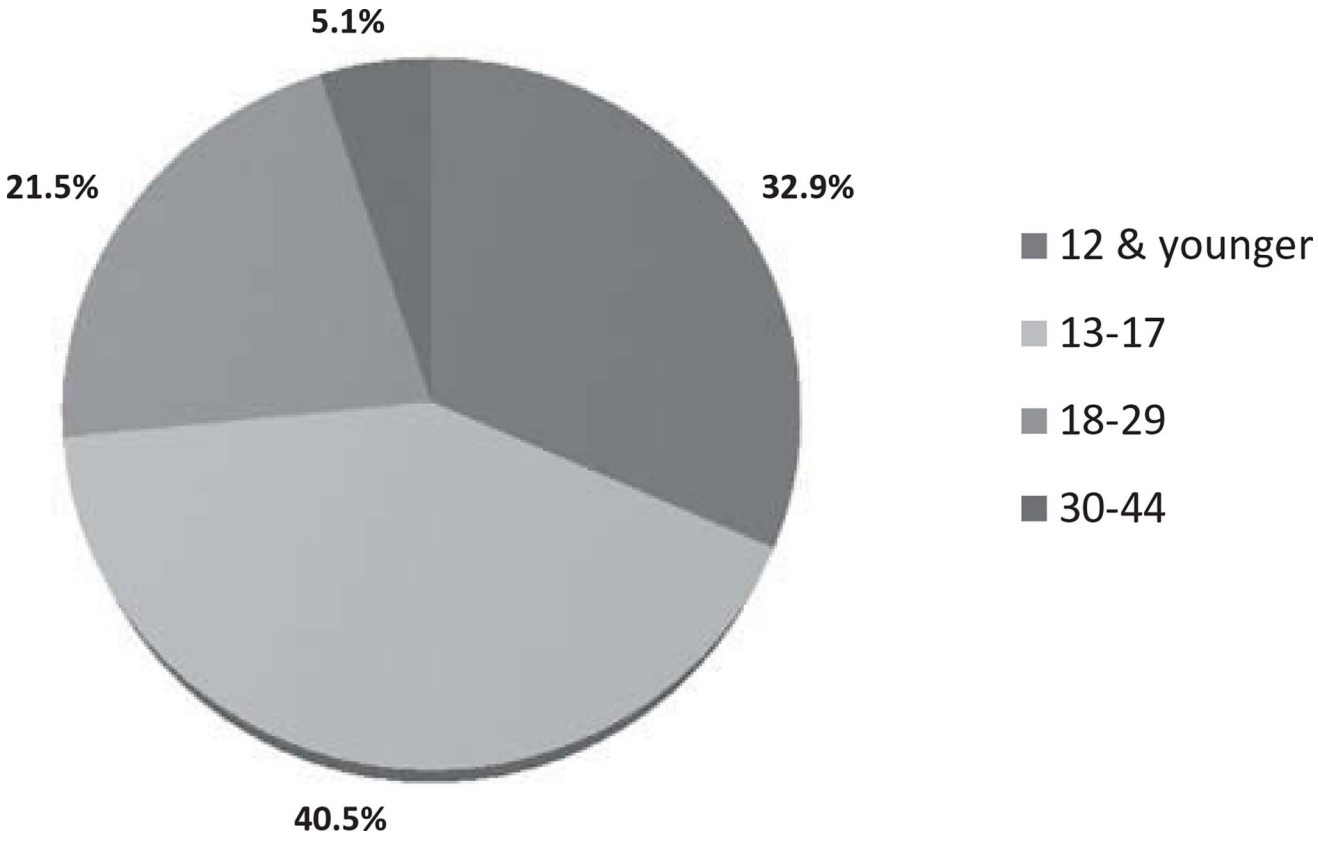

Figure 3.

Age at victim's first unwanted sexual experience: Victims of rape or sexual coercion (N = 79). One participant was excluded because she could not recall her age at the time of her first unwanted sexual experience.

Table 1

Lifetime Mental Health Experiences by Victim Status of Rape or Sexual Coercion.

	Victim		Nonvictim		Total	
Participant has experienced	**%**	***n***	**%**	***n***	***N***	**Chi-square**
PTSD symptoms (any)	67.31%	70	32.69%	34	104	13.7986*
Nightmares	72.41%	42	27.59%	16	58	9.3428**
Avoided situations that reminded her	68.67%	57	31.33%	26	83	9.7904**
Constantly on guard or easily startled	71.64%	48	28.36%	19	67	11.5359*
Felt numb or distant from others or activities	75.00%	45	25.00%	15	60	14.1523*
Depression symptoms (any)	74.39%	61	25.61%	21	82	22.2826*
Felt sad, down, or hopeless for 2 weeks or more	76.81%	53	23.19%	16	69	20.7523*
Little interest or pleasure in doing things for 2 weeks or more	75.71%	53	24.29%	17	70	18.5358*

Note: Percentages represent proportion of victims or nonvictims of rape or sexual coercion who endorsed the mental health experience. PTSD = posttraumatic stress disorder.

* $p < .001$.

** $p < .01$.

Table 2

Victim Age and Perpetrator Type Among Those Whose First Unwanted Sexual Experience was Rape or Sexual Coercion.

	Intimate partner		Family		Friend or acquaintance		Stranger		
	n	%	*n*	%	*n*	%	*n*	%	Total *N*
12 and younger	1	3.9	11	42.3	12	46.2	2	7.7	26
13–17	9	28.1	2	6.3	17	53.1	4	12.5	32
18–29	8	47.1	0	0.0	7	41.2	2	11.8	17
30–44	2	50.0	0	0.0	2	50.0	0	0.0	4

Note: $N = 79$. One participant was excluded because she could not recall her age at the time of her first unwanted sexual experience.

Table 3

Consequences of First Unwanted Sexual Experience (Rape or Sexual Coercion).

	Yes		No	
Consequences	**%**	***n***	**%**	***n***
Physical				
Injured	39.7%	31	60.3%	47
Minor bruises or scratches	93.6%	29	6.4%	2
Cuts, major bruises or black eyes, knocked out	40.0%	12	60.0%	18
Contracted HIV	3.8%	3	96.2%	76
Contracted a sexually transmitted disease	7.8%	6	92.2%	71
Lost existing pregnancy	3.0%	2	97.0%	65
Became pregnant	17.9%	12	82.1%	55
Birthed and kept the baby	58.3%	7	41.7%	5
Miscarriage	25.0%	3	75.0%	9
Abortion	16.7%	2	83.3%	10
Services				
Needed medical services	35.1%	27	64.9%	50
Able to get medical services	55.6%	15	44.4%	12
Hospital stay	5.1%	4	94.9%	74
Rape kit exam was performed	15.4%	12	84.6%	66
Needed mental health services	36.2%	29	63.8%	51
Able to get mental health services	51.7%	15	48.3%	14
Needed community services	13.9%	11	86.1%	68
Needed housing services	12.8%	10	87.2%	68
Needed victim advocacy services	12.8%	10	87.2%	68
Police were contacted	26.3%	21	73.7%	59
Daily life				
Stayed with family or friends afterward	38.0%	30	62.0%	49
Relocated or changed residence afterward	32.5%	26	67.5%	54
Missed work afterward	6.3%	5	93.7%	75
Felt unsafe in neighborhood afterward	42.3%	33	57.7%	45